

**U.S. Department of Veterans Affairs
Capital Asset Realignment for Enhanced Services (CARES) Commission**

Second Meeting
March 11-13, 2003
Washington, D.C.

Meeting Report

Commissioners in Attendance:

Everett Alvarez, Jr., Chairman
Charles Battaglia
Joseph E. Binard
Raymond Boland
Chad Colley
Vernice Ferguson
John Kendall
Richard McCormick
Richard Pell, Jr.
Robert A. Ray
Sister Patricia Vandenberg
Raymond John Vogel, Vice Chairman
Jo Ann Webb
Michael K. Wyrick
Al Zamberlan

Richard E. Larson, Executive Director

Tuesday, March 11, 2003

The Vice Chairman, Mr. Vogel, opened the meeting by welcoming the Commissioners, announcing that Chairman Alvarez would join the meeting by mid-morning. He reminded the Commission of the briefings it received in February and said that the agenda for this month would build on those briefings. Noting it has been said that "the best way to predict your future is to create it," Mr. Vogel said that the Secretary and Dr. Roswell were telling the Commission last month that CARES is necessary both to predict the future of VA healthcare and to set the path for it. The Commission also heard from the National CARES Program Office executives and staff about the process being used. All of the presenters emphasized how important it is to enhance the VA health care system to meet the needs of today's and tomorrow's veterans. The information the Commission will get in this meeting will enhance its knowledge of CARES so it can

provide sound decisions and recommendations to the Secretary and he, in turn, can make confident, knowledgeable and meaningful decisions about the VA's national system.

The Commission's Executive Director, Richard Larson, acknowledged that the agenda for this meeting is demanding, but it is necessary. At its first meeting, the Commission received a high-level overview of the CARES process. Today's agenda will allow the Commission to drill down deeper into the details of the program with the experts who have been working on CARES for the past 18 months. As was discussed at the first meeting, the Commission will be asked at a future meeting to decide whether the model being used for CARES is reasonable. The briefings the Commission will receive this month should help it in making knowledgeable recommendations to the Secretary about the model.

Mr. Larson summarized the agenda for the meeting. Today, the Commission will get a detailed presentation on the CARES model from Kathi Patterson, a representative of the firm that developed the model for VA. Tomorrow morning, Ms. Patterson will return for a question and answer session on the model. This afternoon, the Commission will meet in administrative session to discuss organizational matters.

The agenda for Wednesday morning (March 12) includes in-depth briefings on the CARES program design, market area development, gap analysis and access definition. Wednesday afternoon's agenda will focus on CARES Planning Initiatives and how they were developed. At 3:00 P.M. on Wednesday, the Commission will hold breakout sessions with the three teams that it will use for the field hearings. At 4:00 P.M., the Commission will reconvene and Commissioners will have an opportunity to share their thoughts on the process so far and inform about additional needs.

The Thursday agenda (March 13) includes in-depth briefings on the planning models used for long-term care and special disabilities populations and a discussion of market planning criteria. On Thursday afternoon, the three teams will meet again to discuss their information needs and processes.

Presentation and Discussion
CARES Demand Model
Ms. Kathi Patterson, CACI/Milliman

Allen Berkowitz of the VA Auditor's Office introduced key staff from CACI/Milliman, an actuarial firm and the contractor responsible for developing the model that VA uses for projecting enrollment:

- Mike Loudon, Senior Vice President of CACI, who has visited numerous VA facilities and conducted many focus groups to identify veterans health care needs.
- Kathy Lough, a Senior Manager at CACI and the Contract Manager for the VA modeling program.

- Duane Flemming, who as the Contract Officers Technical Representative (COTR); the prime contact for the Commission with CACI/Milliman.
- Kathi Patterson, a principal at Milliman USA and a Fellow of the American Society of Actuaries. She has worked extensively to improve the veteran enrollment and projection model for the past five years. The Enrollment-Level Decision Analysis Model (ELDA), with adjustments, was used by the CARES program as the model for projecting future demand for VA health care services.

Ms. Patterson presented the details of the model to the Commission.

Ms. Patterson began by saying that it has been both fun and interesting to develop the *enrollee health care projection model* for VA. Unlike most health care service models, which are supply models, the VA model is a *demand* model, which is fairly new. It projects both utilization and expenditures for the enrolled veteran population.

The model is unique to VA. It is based on private sector benchmarks, but these are completely adjusted for the VA population and for how the VA delivers care. It provides very detailed projections for about 50 different health care service lines. This provides a very large amount of detail in the model.

The initial version of the model was created in 1996. It was a global model that projected only one year for seven VISNs. Since 1996, the model has been enhanced often. A large amount of data has been added to the model on the VA side. Projections have been extended to 20 years. Additionally, the model has been made less reliant on survey data and more reliant on VA experience.

Making projections 20 years out is a real "push" for the health care field; a lot can change in that period of time. In response to a Commission question, Ms. Patterson said that in order to test the accuracy and validity of the model 20 years out, her firm has developed test scenarios with lots of assumptions. This results in a flexible model that can be modified when conditions change. In the case of VA, there have been "lots and lots" of adjustments made.

She characterized the enrollment projection model as essentially as "piece of paper" -- a matrix with many cells. CACI wound up doing the model at county level for four VA priority levels, 22 VISNs and different types of enrollees. The results was over eight million different versions of the model for VA staff to deal with. This has greatly increased the complexity of the model, but has also made it more beneficial. The model is now more flexible and useful for many purposes. The team is continuing to enhance the model every year.

The primary use of the enrollment level decision analysis model is for the Secretary's annual enrollment decision. However, it is also being used for CARES baseline projections and analyses as well as for enrollee cost-sharing analysis, budget formulation, market analysis and unmet demand analysis, scenario testing, policy decision analysis and special analyses.

Discussion of Unmet Demand and the Model

Noting that unmet demand is a very important consideration for the field, a Commissioner asked how the model quantifies unmet demand. Ms. Patterson replied that unmet demand is an issue. It was not considered in the model used for CARES. Ms. Patterson stressed that the model is a *health care* model -- it doesn't include demand for the other types of services that VA provides. As a follow-up, Ms. Patterson was asked how the Commission could expect to make decisions that are satisfactory to everyone involved if it doesn't know what demand is not being met now? Ms. Patterson replied that the model projects where VA needs to be at a minimum based on where it is now. But it is a *current* demand model, not an unmet demand model.

A Commissioner pointed out that there are two types of unmet demand: the unmet demands of enrollees and the unmet demands of those veterans who do not enroll because they know that the VA system doesn't provide what they need. The Commission expects to hear from stakeholders that "If you build it, we will come," that is, that they would use the services if they were available. It will need to deal with this issue. It is a very important consideration and the Commission will have to have a general idea of such matters as how long the wait time is for services. It will be very difficult for the Commission to go out to the field for hearings without knowing.

Ms. Patterson replied that there has been some quantification, but only on a facility-by-facility basis. The question of whether the market is offering what the veterans want and need is a very difficult one. The answers will differ greatly depending on what market is being looked at.

Several Commissioners agreed that the need is to identify what 100 percent care would be. Then it would be possible to say what is not being provided and why.

Other Questions and Answers

Ms. Patterson was also asked what the difference in the VA budget has been as a result of using the model. Mr. Larson answered that question by indicating that the staff would research the matter and get back to the Commission with an answer.

A question was asked about the use of survey data. Ms. Patterson said she would talk to that later in the presentation.

A Commissioner asked whether there had been any reason to compare differences in enrollee data from one region to another. Ms. Patterson replied that there had been and that the model is able to do that. As a follow-up, it was asked whether she had any judgments about why some areas have so many more enrollees than others. The answer was that veterans tend to congregate in certain geographic areas. She said that it is possible that VA might also have a reputation in some areas that affects enrollment.

A Commissioner asked how the Commission could get at the reasons why all VISNs don't try to meet the same demands. It was suggested that the Commission should ask the VISNs directly. At the local level, the VISNs know their own systems and can interpret why certain things happen.

A Commissioner, noting that 35 percent of the veterans in North Dakota use the VA system whereas only 10 percent of those in Michigan do, asked to what extent this kind of information is captured in the model. Ms. Patterson replied that this situation as well as the other things that the Commission is asking about are embedded in the many assumptions included in the model - except not unmet demand. Unmet demand is specifically excluded. She said it would be possible to spend many hours talking about how unmet demand might be modeled.

Asked whether there is a National policy regarding who can enroll, Ms. Patterson replied that she would also get to the answer to that question later in discussing the model's details.

Model Attributes

Ms. Patterson continued her presentation by explaining that the model is not a "national" model -- it was built by aggregating demand from the bottom up (i.e., beginning with the smallest sub-population and rolling up). This feature is very important for a lot of scenarios. At this level, supply plays a role. If VA doesn't offer a service -- maternity care, for example -- that is built in to the model. That has to be considered because it affects the reliance factor -- the extent to which veterans rely on the VA system for their health care as opposed to other systems.

The model is very flexible. It is possible to change assumptions, to re-run the model and see what happens. CACI has spoken with OMB about the model every year since it was initiated and has also briefed GAO and VA's Office of Policy and Planning in addition to the Office of the Actuary. These discussions have resulted in numerous modifications and improvements.

Detail of the ELDA Model

Ms. Patterson explained that the ELDA model is actually two main models: enrollment projections and expenditure projections (enrollment, utilization and cost). The original ELDA model, which was built on a "preferred facility" basis, was modified to provide:

- County-level data,
- Four age bands (under 45, 45-64, 65-84 and 85 and over)
- Enrollee type ("enrollee-pre" and "enrollee-post"),
- Priority level (1-A and -B, 2 through 6, 7 and 8-A and -B).

Projections are provided for approximately 50 health care service lines.

Enrollment Projections

For modeling purposes only, enrollees are divided into two types: (1) "enrollee-pre" -- consisting of those individuals who used the system prior to the enrollment policy decision and who are currently enrolled; and (2) "enrollee-post" -- consisting of individuals who didn't use the system prior to the enrollment policy but who are enrolled now. The model recognizes different characteristics for these two groups and assumes different behavior.

The model can project enrollment up to 24 years in the future. The starting point is VA baseline data from October 1998 to December 2001. Data from the VetPop model (originally the 3.06 model and now the 2000 Census model) was used to develop a "VetPop Proxy" that projected the total target population. Figures were adjusted for priority level, age, gender and location. New DoD separations and mortality were factored in to arrive at total population projections by county. In answer to a question, Ms. Patterson said that race is not a factor in the adjustment and she has no data on whether it is a factor in enrollment. In answer to another question, she said that the model has already been re-run using 2000 Census data.

To project future enrollment, an "enrollment pool" was created. The pool is made up of all the veterans who are eligible to enroll but who haven't done so. Because this enrollment pool is fixed, the system knows exactly what it looks like in terms of age, priority level, and geographic distribution. To project future enrollment, the model applies an enrollment rate to the pool. A 13-month period was studied to derive the enrollment rate. Enrollment from the pool has been relatively constant by priority level, age band, county and enrollee type.

Ms. Patterson was asked whether the model differentiates between enrollees who use the system and those who don't. She replied that veterans in the "enrollee-pre" category are heavy users of the system, while "enrollee-post" veterans use it less.

Ms. Patterson was also asked what the "drivers" are that determine future enrollment. She replied that the model assumes that whatever was driving enrollment during the 13-month period studied to derive the original enrollment rate will continue. It would be possible to change the assumption and re-run the model, but for right now the assumption is that the enrollment rate will continue without change. The impact of this is that because the total veteran population is projected to decline in the future, the size of the pool will also decline and growth in enrollment will be slower.

The ELDA model starts with the VetPop projections and breaks them into two groups: (1) veterans already enrolled, and (2) veterans in the pool. Every month the system acquires new enrollees from the pool, but there are also deaths in each of the two groups along with new veterans coming into the pool from DoD. The enrollment rate determines how many veterans will move from the "pool" to the "enrollee" side of the equation. The rate is constant, although it doesn't look like it on a national level. Each priority level

group has its own enrollment rate because the pools for each priority group are a different size, but the rates are constant.

Ms. Patterson was asked about the differences in characteristics by priority group. She replied that the demographic data are available and would be made available by Mr. Berkowitz later. She was also asked why the numbers are growing when the total universe, that is the number of veterans, is declining and the enrollment rate is constant. Ms. Patterson replied that the enrollment grows until 2012, when it peaks and then begins to decline.

One Commissioner observed that enrollment for priority groups one through six is driven by the priority fives, which are the biggest population. He asked whether the projected number of future priority fives takes into account the aging of the group and economic changes. Ms. Patterson replied that the aging of the group is taken into account, but not economic changes. The Commissioner observed that retirement has an effect on income -- there is less money in retirement. Ms. Patterson said that the model doesn't have the data to take into account that migration. The Commissioner said, and Ms. Patterson agreed, that work should be done on this factor because a huge number of Vietnam veterans in priority group five will be reaching retirement age.

Another Commissioner observed that there could be surges in the number of incoming veterans. It would have been difficult to foresee in 1935, for example, that there would be 16 million new vets in 1945. He asked how the model deals with that possibility. Ms. Patterson replied that surges of this type would normally be included in the Vet Pop model. The ELDA model has the option of letting the VetPop model handle the surge or changing the assumptions. Another Commissioner noted that conflicts are a cyclical phenomenon, so it's a good bet that you'll have one on a recurring basis. He asked if that could be built into the model. Ms. Patterson said that the model could be modified to do that.

A Commissioner asked Ms. Patterson to comment on the projected growth in enrollment, observing that the reason is probably economic. Ms. Patterson replied that overall growth would go from 6.6 to 8.3 million between 2002 and 2022, but that the projected growth is in the pool for priority group seven. The pools for priority groups one through six are not as large.

Utilization Projections & Adjustments

The utilization projections included in the CARES model are based on *private sector benchmarks* for about 50 specific health care services. These are adjusted to fit the VA system. Adjustments vary by service line and by geographic area. Benchmarks are specific to individual geographic areas and vary by Metropolitan Service Area (MSA). CACI/Milliman uses large nationwide databases with extensive detail that it has been collecting for many years. There are separate benchmarks for the commercial sector and for the Medicare over-65 program. CACI benchmarks are used extensively by the private

sector. They are a "gold standard" look at health care services. These benchmarks are validated, credible and updated annually.

In response to a question, Ms. Patterson said that the model doesn't use cost data. It is difficult to model using Medicare data because of the program's complexity. But they have made other accommodations.

Some adjustments to the overall model do not affect the model used for CARES -- Millenium Bill services are one example; VA special beds, which are modeled separately, are another. But many important adjustments have been made to fit the benchmarks to VA. One is the *medical benefits* package, where VA is very different from the private sector. The VA package is very comprehensive -- practically unlimited. Another adjustment is made for the impact of VA *co-pays and unlimited benefits*.

A major adjustment is made for the *age and gender* of the VA population. The veteran population is mostly male (unlike Medicare, which is 60 percent women) and includes no children. Further, the VA under-65 population tends to be older than the general US population. Specific age and gender adjustments are made for each health care service -- they are all different.

Reliance Adjustment

Another major adjustment is for *reliance*. Unlike the private sector, where other sources of health care are not available, the VA is not the only source of health care available to veterans. Reliance varies from zero to 100 percent -- from nothing to all. The reliance adjustment is based on a survey of enrollees. The survey determined where veterans get their health care, and who pays for it, based on the number of office visits (if three out of ten office visits were to VA facilities, for example, there is 30 percent reliance on VA). The survey showed that enrollees tend to be "almost fully reliant" or "not at all reliant" on the VA system. Very few pick and choose, although reliance may vary by health care service category.

The survey was used to develop the initial reliance estimate, but it was validated by cross-checking the results against Medicare/Medicaid data for enrollees 65 and over. VA obtained the Medicare/Medicaid data with a contract to the Centers for Medicare and Medicaid Services (CMS) -- which was formerly known as the Health Care Financing Agency (HCFA). The cross-checking enabled the modelers to look at specific services by enrollee category, age group, priority level and VISN. The results again showed that reliance varies by service category and also according to the other factors (enrollee type, age group, priority level and VISN). However, it is still the case that enrollees who come to VA, on a service-by-service basis, tend to come to VA all of the time and those who don't use VA don't use it for any services.

Because the CMS data validated the survey results for the over-65 enrollee population, it was possible to use the survey data for the under-65 population as well.

In answer to a question, Ms. Patterson said that the survey was for the years 2000 and 2001. She was also asked about the results for pharmacy services, but said that pharmacy services are estimated using a method other than the survey.

Ms. Patterson noted that the reliance factor is affected by what VA offers (as it would have to be) and that the reliance adjustments reflect what the enrollees have sought from VA. She stated that it would have been easier to do a national-level model -- it is difficult to do modeling at the smaller geographic levels. However, the CARES process made it clear that reliance can vary from market-to-market, so the modeling was done at that level.

A Commissioner asked how much exposure the VISNs have had to the model, whether it is part of their daily life and whether they are eager for more exposure. The answer provided was that the VISNs first big exposure to the model was CARES. Most have only been using it for three or four months. Different VISNs have had different reactions to the model. When they get their own data, the VISNs usually begin asking for more. Mr. Berkowitz added that most field people relate more easily to "treating facility" data; national-level population data doesn't get their attention.

One Commissioner spoke to a radical change that DoD had made to their system in the '90s. He said that new mandates sent everyone scrambling for a tool to show how the changes would impact the system. He said something like that might be working here. Ms. Patterson acknowledged that it may have been difficult for VA people to grasp what the model was all about. She said it has been an uphill battle getting people to understand and believe in the model. In answer to another question, she said that on a national level, data were very close when compared to the model previously used.

A Commissioner commented that when DoD changed its system so that people would either have to opt in or opt out, people chose to enroll, but many didn't use the system at first. When health care costs started to rise, system use went up, so an economic factor clearly is involved.

Ms. Patterson was asked whether it is possible to make a determination about *why* people are or aren't using the system or are using it part time. Ms. Patterson said she believes that the VISNs know their own markets. They have answers to the questions at the local level.

A Commissioner said that he has heard that VA doesn't know how many enrollees use VA only for prescriptions. The answer given was that some analysis has been done in an attempt to get at "pharmacy only" users. The results suggest that there are not many enrollees who use the system just for pharmacy, although some people are very heavy pharmacy users. The service category data includes pharmacy.

Discussion among the Commission indicated that it can be very easy to get a prescription filled at VA. The recommendation was made that growth in the pharmacy budget should be reviewed to find out how much is caused by increased enrollment as opposed to

increased use. Prescription costs are a huge driver that is bringing people into the VA system. A Commissioner commented that if a significant number of enrollees are "meds only," that would reduce infrastructure costs.

Another Commissioner commented that the survey doesn't ask whether enrollees get prescriptions from outside the system. Another commented that the reason for pharmacy only is accessibility. Enrollees might like to get everything from the VA, but it just isn't possible. Another Commissioner expressed the view that the key factor is certainty of care -- whether you can get what you need on a family basis. His view is that this factor supersedes all others in the decision about whether to use the VA system. Another Commissioner noted that ease of access is also important. When he wants a prescription filled, he'd rather be able to just go down to the store on the corner and not have to go to a VA pharmacy every time.

Ms. Patterson was asked whether definitive data could be obtained for the over-65 population. She replied that she didn't know, but that they were trying to get it.

A Commissioner said he thinks that if CACI were to look at the data for an average priority group seven-C patient, it would find that the pharmacy costs were much higher. This would result from the VA definition of "one visit per year." At VA, enrollees can get a prescription with one visit per year. Ms. Patterson replied that CACI could re-run the model with whatever assumptions the Commission wanted to use.

Another Commissioner asked whether there was data on people who have other providers. Ms. Patterson replied that such data exists for only one year. The model relies instead on the survey and its relationship to CMS data. Asked whether Medicare wouldn't know whether and how much enrollees are using outside of the VA system, Ms. Patterson replied that Medicare is the something else. A very high percentage of veterans -- about 3 million of the 6 million -- are in the over-65 category.

Ms. Patterson said that the impact of treating facility wait lists is important to "reliance." The wait lists keep growing. She repeated that reliance is impacted by what VA has to offer. It is possible to get at "pure demand." What VA offers is an important constraint.

Morbidity Adjustment

Another important adjustment made to the model is for *morbidity*. Historically, VA patients have been sicker than private sector patients and veterans perceive themselves that way. There are lots of different ways to measure morbidity. For the VA model, CACI is using a diagnosis-based adjustment system. This method compares diagnoses of VA enrollees with those of the private sector. Each diagnosis has a risk factor associated with it.

The model focuses on data in the chronic disability payment system. Only four major categories of morbidity can be varied: inpatient and outpatient, mental health and non-mental health. The results indicate that morbidity varies according to enrollee type, age

group, priority level and VISN. Priority level four has the highest morbidity. For many priority groups, veterans are healthier than the private sector population. Some morbidity adjustments are huge.

In response to a Commissioner's question, Ms. Patterson said that economics is not factored in to the morbidity calculations. Another Commissioner asked whether accessibility to services was a significant determinant of morbidity. Ms. Patterson replied that they had done an analysis of veterans who were heavily reliant on VA and compared them to veterans who were only partially reliant. There was no major difference. Consequently, CACI used the enrollee population that is very reliant on VA in making the morbidity adjustment.

Degree of Community Management (DoCM)

Ms. Patterson explained that CACI/Milliman also adjusts the model for *degree of community management (DoCM)*, an indicator of how tightly controlled a health care system is. The private sector measures health care management on a scale of zero percent (loosely managed) to one-hundred percent (tightly managed). CACI tries to fit VA healthcare into that spectrum. The key indicator CACI looks at in making the DoCM comparison is "length of stay in acute beds." This method takes actual inpatient bed-day data, assigns it to a diagnostic related group (DRG) and adjusts for severity. CACI has private-sector benchmark data on "length of stay" for every DRG. The VA data is compared to those benchmarks and "excess days" are calculated. Benchmarks vary from region to region (i.e., the zero percent end point changes by region) so CACI also varies the VA data that way. The model also varies adjustments by health care service line and by fiscal year. Patterns of practice vary across the country and VA patterns mirror those of the private sector on a regional basis. This makes sense because the private sector and VA are hiring from the same pool. CACI focuses on identifying the differences between what VA does and what the private sector does.

Generally, VA tends to be "loosely managed" and the model assumes that VA is moving more in that direction every year. CACI has no data on outpatient services, so the model assumes that VA's outpatient services are also "loosely managed." Again, the assumptions can be adjusted if desired.

The discussion of DoCM centered on data comparability. A Commissioner observed that for benchmarking purposes it is critical to compare "apples to apples." For acute psychiatric care, the definition of "acute" is critical. He said the fact the model used a 75-day cutoff in defining "acute" is bizarre. Twelve percent of VA patients had lengths of stay of more than six months. This means that CACI took VA's "chronic" mental health care and called it "acute." He asked how CACI justifies this. Ms. Patterson replied that for bed section cases, anywhere that there might be an acute stay, the case was individually examined to make a determination. CACI used VA people to help determine what was "long term" and what was "acute." In looking at private sector benchmarks, CACI attempts to remove the impact -- it just wants to model what VA does.

The Commissioner said he believes CACI should have started at a different place. But since it didn't have the data to start there, it started where it did have data and adjusted from that point. He said "the devil is in the adjustment." He would like the model to use a comparable set of VA patients to what the private sector calls "acute." Ms. Patterson said that for stays of under 70 days, VA data was compared to what is in the private sector for the same category.

The Commissioner said the key issue is how many beds are affected -- both the bed base and the assumptions. In his view, a 65-day length of stay is not "acute." Since the definition is not right, it should be changed; any benchmarks used in the model should be right. Ms. Patterson noted the "degree of community management" is an assumption that can be changed and that the impact of DoCM on the overall model isn't great. The Commission agreed to flag this matter as an issue to be addressed through further discussion.

Another Commissioner asked whether there is information on Medicare outpatient management for HMOs. Ms. Patterson replied that the data exists, but in the case of VA, the veteran has control. He can decide whether to access the system or not. This is not the case in the private sector. She added that DoCM is an indicator that is more critical for inpatient than outpatient services.

Ms. Patterson was asked if the assumption is that long inpatient stays affect whether or not veterans use the system. It was also noted that the term "loosely managed" may imply that VA is doing a bad job and that the terminology may be problematic. Ms. Patterson said that was not the case. The private sector benchmarks are built on indemnity care systems. CACI is just trying to place the VA system where it properly belongs on that scale. The terminology used is a private sector definition.

Residual Differences

The final set of adjustments made to the model are for *residual differences*. These adjustments are made to reflect the actual-versus-expected performance of the model. Ms. Patterson characterized them as being a "real bear." After CACI made all of the other adjustments, they ran the model and compared it to actual experience. The purpose was to see how well the model predicts (it was not expected to be perfect). CACI looked at how well the model did at predicting actual service lines and made adjustments accordingly, then at predictions by priority category and made further adjustments. The residual adjustments also reflect unmeasured morbidity, reliance and DoCM. These adjustments were considered not appropriate for CARES.

Ms. Patterson was asked how big were the residual adjustments. She replied that for some categories (such as allergy immunotherapy) CACI had to make big adjustments. On the whole, however, the model does reasonably well. Asked if adjustments were made for all 50 health care service lines, Ms. Patterson said they had not -- some were so small that they had to group them together.

In response to another question, Ms. Patterson said that adjustments do not reflect local VA supply constraints (which are unique for priority group four). The model includes supply constraints only on a national level, not the VISN level.

Ms. Patterson closed out the subject of "adjustments" by noting that she hasn't discussed some of the smaller adjustments. However, the Commission's notebook includes a table that displays a comprehensive list of all the major adjustment factors used. In answer to a question about the table, she said that the unit used is "rate per thousand enrollees."

Unit Cost Projections

Ms. Patterson introduced the subject of unit cost projections in the model by observing that they play a role in CARES, but not to the same extent that they play a role in other processes.

VA unit cost data are expressed in terms of "price per day for service." Unit cost projections are not used in CARES modeling. CARES is more concerned with workload and with the cost of obtaining care outside the VA system. The benchmarks used for the model have "Medicare allowable" unit costs which are geographically adjusted. For prescription drugs, there is no such thing as "Medicare allowable" unit costs. The model reflects VA costs.

Tabular data were presented showing how the adjustment factors used in the model vary by priority level and by VISN. By priority level, the priority sixes had to be modeled separately. Because of the group's small size it was hard to model. Ms. Patterson said that this group looks like the priority sevens in many respects, but there are exceptions. Priority fours are the most expensive; priority sevens are "relatively cheap" (because of their low reliance on the system; and priority fives are "holding their own." On the average, enrollees are only 40 percent reliant on VA, but are sicker than private sector patients. The adjustment factors don't vary as much by VISN as they do by priority.

In response to a Commission question, Ms. Patterson said that decisions about what assumptions to use in developing the model were made by the National CARES Office along with others (subject area experts, for example). She said the answer depends on what level of the model you are interested in. She can find the information for specific factors.

Ms. Patterson also presented tabular information comparing the costs in each VISN to National VA costs. VISN four is the least expensive area. Ms. Patterson was asked about the meaning of the national norm of 1.00. She replied that the model is very interactive and the factors affect each other ("reliance" affects "morbidity," for example). The table she displayed shows how the factors vary by VISN on a relative basis.

Expenditure Projections

Ms. Patterson described the computation of expenditures as involving: enrollment times utilization times unit costs, at the greatest level of detail. Unit costs are expressed in terms of per member (enrollee) per month. A sample cost model is included in the materials provided to the Commission (Attachment A). She noted that the per member per month dollar figure shows how much more expensive priority levels one through six are (at \$330 per month) compared to priority level seven. The figures shown are actual numbers for 2001; other years are projected. In response to a question, Ms. Patterson said that all of the figures shown are adjusted for inflation.

Discussion/Q&A:

One Commissioner asked about outpatient data and how it was derived. He said that there are standards for outpatient utilization. The Department of Defense estimated a standard for outpatient use by specialty so that it could measure providers against that standard. Their data was taken from management sources, then modified by clinical review people.

There was additional discussion of unmet demand and how the Commission might get a handle on it. One Commissioner commented that if the model doesn't address this factor, the numbers don't mean much. Another asked whether other organizations have developed models that address unmet demand. Ms. Patterson said again that there is no unmet demand currently included in the CARES model, and she doesn't know of any other organizations that might have models that address it. But there are ways of getting at it -- how many private sector providers there are by specialty, etc. One Commissioner commented that other organizations' estimates of unmet demand are always higher than VA's. Ms. Patterson said she didn't know how they got those numbers.

A Commissioner remarked that the VA move from inpatient to outpatient emphasis has worked well. But without knowing unmet demand, there is no way to tell which clinics need full service care and which other facilities need what services. As a Commissioner, he wants to make sure that he knows what VISNs are offering now, before he goes there.

Another Commissioner commented that DoD built facilities based on historical use rates. Estimating the markets should help establish a specific utilization pattern -- what gets used and when. Once you have this information, you can re-shape the system to meet the demands. In response, another Commissioner said he sees the Commission's job as being much bigger and broader -- it is looking at a bigger range of care.

The comment was made that the "fundamental civilian population" should be the starting point. Then factor in the differences. In reply, it was noted that the veteran population is very different so that might not be the best way to go.

When DoD went through its Base Reduction and Closing (BRAC), VA was still operating in the "inpatient mode." When VA opened clinics in the places where BRAC closed hospitals, enrollment jumped. We should learn from that experience. Myrtle

Beach, S.C. was cited as an example of a locality in which VA enrollment jumped significantly after DoD closed the military base there. Others commented that experiences like this are very localized and can't be projected nationwide.

Discussion indicated that when VA opened its Community-Based Operating Clinics (CBOCs), 80 percent of the patients were new patients who had never used the system before. It was suggested that the CBOC experience should be studied and used for future modifications. The system needs to evolve to the point where data is available. The time factor is important. The model and its projections are showing tremendous growth in enrollment.

The Commission concluded that a core issue for them is that the private sector benchmarks used in the model don't allow for what VA is failing to do now. The model doesn't consider either the unmet needs or what the various clinics are providing.

Ms. Patterson replied that CACI looked at enrollment and at the rate of enrollment out of the pool. The model assumes there is some growth and that the access rate will stay the same. So, at a minimum, the projections don't exacerbate the unmet demand and might even handle some of it. She agrees, however, that it may not provide for meeting all of it. Unmet demand is not specifically calculated but is embedded in the pure modeling. Enrollment is growing from the same pool, so the system will be serving more enrollees and meeting some of today's unmet demand. Unmet demand may vary significantly by region, but it is not being excluded or ignored. She acknowledged that unmet demand is a very difficult issue and she understands the desire to model it.

A Commissioner suggested again that the Commission should take the "unmet demand" issue to the VISNs.

Modifying the Model to Support CARES

The ELDA model was modified especially to support the CARES process. To use the model for CARES, the health care service lines were converted to CARES specialty categories and demand at that level was allocated to treating facilities. Projections were made at the five-digit zip code level using 2001 baseline data (what actually happened in 2001). Different scenarios were also modeled and consultation support was obtained for selected categories.

For the CARES model, CACI developed an allocation methodology that translates workload projections from private sector categories into the 16 CARES categories and units that VA is accustomed to. This allowed the model to give VA data that is directly compatible with its space driver. CACI monitored the integrity of the utilization projections. It analyzed private sector utilization patterns and developed an appropriate allocation process for each CARES category.

Inpatient CARES categories included medicine, surgery, mental health, domiciliary and special disabilities. Outpatient categories included primary care, specialty care, mental

health and geriatrics. Non-clinical categories provided space projections related to administration and research.

A Commissioner asked what was the basis for subdividing the categories, for example, to have "cardiology" and not "surgery". Discussion indicated that the underlying basis for the subdivisions of the CARES categories was "space" -- CARES is a space allocation process. Another Commissioner commented that for mental health, an affiliated medical center will look much different in these categories from an unaffiliated one. This is because the figures are based on private sector data, not on what VA did.

Ms. Patterson explained that demand in the CARES model was projected using "procedures" as a unit of measure whereas the VA unit of measure is a "clinic stop." To match VA units, the model converted "procedures" to "clinic stops" at market level. The Commissioner's binders have a matrix (Attachment B) that shows cost models by CARES categories. In answer to a Commission question, Ms. Patterson said that the benchmarks used were from the commercial data base.

The total veteran population (projected to 2022) was allocated to treating facilities based on the existing infrastructure. As the workload went up or down, the projections were held constant, although the mix might vary. This analysis involved extensive credibility analysis and smoothing. (Ms. Patterson noted that with credibility there needs to be a large sample to work with. If the population is chopped up into smaller pieces, anomalies are introduced. The modelers aggregated the projections to avoid this outcome.)

The total veteran population was also allocated to zip codes at the five-digit level. Enrollment was then re-projected by zip code as a means of developing appropriate zip code clusters.

The workload was summarized using different cuts to create a big database of what actually occurred in 2001. This allows "apples-to-apples" comparisons. Baseline data was summarized using the CACI/Milliman methodology and the VA methodology (there's a difference). This data was then divided into categories for purposes of gap analysis.

Special consultations were also conducted in developing the CARES model. These included extensive work with the Mental Health Work Group. They also worked with the VISNs on reliance and reliance issues, especially where reliance for a given VISN was very different from the VISN average. CACI worked with the VISN Service Support Center (VSSC) to help them understand the projections, the increases and decreases and their causes and how to analyze the model.

Scenario Modeling

Ms. Patterson said that the CARES program knew it would need to run different versions of the model for different assumptions. Some versions have already been constructed and run, but it would be possible to do more. Scenario modeling allows decision-makers to

see how changing selected factors affect the outcome of the model. Factors that can be changed include enrollment rate assumptions, morbidity, reliance, degree of community management, utilization and cost rate trends, actual-to-expected and VA unit costs.

One Commissioner expressed the view that the VISNs would want to change the "degree of community management" factor. Another asked whether we know how many priority threes are health care enrollees? The answer was that we know the enrollment for priorities one through three.

There was a detailed discussion of the different CARES scenarios that have already been used for: (1) the enrollment level decision analysis model, (2) the interim CARES scenario, and (3) the President's budget policy CARES scenario. Ms. Patterson described the major differences between the three scenarios. They include:

- (a) *VetPop projections* (scenario three is based on the 2000 Census; scenarios one and two are based on 3.06).
- (b) *Enrollment* (scenario one is unrestricted; scenario two limits enrollment to 40 percent with no VISN more than 50 percent; scenario three suspends enrollment for priority level eight).
- (c) *Actual-to-expected adjustment* (scenario one applies a standard actual-to-expected factor; scenarios two and three increase to one any adjustment factor of less than one). Ms. Patterson directed the Commission's attention to the CARES "Actual-to-Expected Adjustment Table (Attachment C), which has a full listing of the actual-to-expected composite adjustments. The table shows projected demand increases by CARES category. The idea here was to remove some of the constraints. In answer to a Commission question, Ms. Patterson said to multiply "bed days of care" by .85 to convert to "beds."
- (d) *Enrollment fee* (scenario three adjusts for a \$250 enrollment fee for priorities seven-c and eight effective as of October 1, 2003. Scenarios one and two include no enrollment fee. The imposition of a fee is expected to affect enrollment.
- (e) *Co-pay* (scenarios one and two adjust for a \$15 co-pay; scenario three adjusts for a \$20 co-pay).

The impact of the different scenarios is not large in the early years, but amounts to a significant difference in the enrolled population in 2022 (approximately 3.6 million enrollees under scenario one, 2.0 million under scenario two and .9 million under scenario three).

Discussion of CARES Scenarios

The Commission briefly discussed whether OMB would object to whatever changes in assumptions the Commission wants to make. It was noted that if the Commission's recommendations couldn't get past OMB, their credibility would suffer on the Hill.

The Commission asked what would be the likely impact of imposing the proposed \$250 enrollment fee. Ms. Patterson said that the scenario shows the proposed fee having a big impact on enrollment, but almost no affect on workload. In answer to a Commission

question about how those estimates were derived, Ms. Patterson said that they came from her Firm's actuarial understanding of consumer behavior with respect to health care. If veterans are users of inpatient services, they will not go away just because of a fee. These are people who like the VA and its services. For prescription drugs, CACI projected users based on different age groups. Ms. Patterson said that, overall, CACI had looked at veterans' "propensity not to pay the enrollment fee." For priority eight veterans, the enrollment for the under-65 age group drops by 54 percent, but bed days of care doesn't change, outpatient visits drop 23 percent and pharmacy drops four percent because of the fee. For the over-65 age group, enrollment drops 50 percent, bed days of care stays the same, outpatient visits drop by 15 percent and pharmacy use drops one percent.

These figures indicate that the proposed fee associated with the President's policy would affect enrollment but have a minimal impact on workload. Ms. Patterson displayed a 20-year enrollment graph to indicate how the different scenarios would look plotted over time. A Commissioner asked what the difference is between scenarios one (the ELDA model) and two (the original CARES scenario). Ms. Patterson answered that there was more of a difference in geographic distribution than in total numbers. For 2001, enrollment doesn't change, but bed days of care go up as do clinic stops.

A Commissioner noted that previous VA projections have shown a big drop off after 2011 as a result of mortality from World War II and Korean War veterans. The current models don't show the same drop and the Commissioner asked why. Ms. Patterson said it's because the model is dealing with enrollment. The mortality will occur, but the constant enrollment rate from the large pool keeps the overall numbers up.

The major difference between the scenarios begins to show up in 2012 (especially the drop in enrollment from the priority eight decision). Bed days of care go up (from the actual-to-expected adjustment) for CARES. For clinic stops there is a slight decline in scenario three (the President's Budget Policy scenario). For 2022, enrollment drops as a result of the President's budget policy decisions.

Several Commissioners, noting that they will have to deal with macro assumptions such as the economy, expressed a desire to have more information about the specific assumptions underlying the quantitative analysis, the basis for those assumptions, and what changes they caused in the model. Ms. Patterson noted that the information they were asking for involved numerous tables of numbers, and she's not really sure that these would be helpful to the Commission. All of the adjustment factors, for example, are assumptions -- even the private sector benchmarks. She suggested, and the Commission agreed, that the Commission would identify its specific needs for additional information.

Wednesday, March 12, 2003

Additional Discussion of the CARES Model

The discussion of the CARES model with Kathi Patterson of Milliman, USA continued on Wednesday morning with a question-and-answer session.

One question concerned the definitions used in the model, specifically the difference between "patients" and "enrollees" and why the model doesn't use "patients" as a unit. Ms. Patterson explained that it is hard to associate a workload -- especially 20 years from now -- with a "patient" because workload can vary tremendously from patient to patient. "Enrollees" is a better indicator of workload. The model is built around claims data. There is also a difference between "users" and "enrollees." The model is built solely on "enrollees." For priority category seven, there is a big difference.

Other information developed during the question and answer period included:

- The reason some specialties, such as urology, are listed specifically in the CARES categories is that the categories were developed based on space requirements.
- Enrollment isn't a recurring process. Veterans only have to enroll in the system one time.
- For modeling purposes, there is no such thing as a "perfect" or "ideal" VISN.
- The VISNs were not using the ELDA model until last year and then only for enrollment. VISNs didn't get the CARES version until this year, so they are just now getting familiar with it. A Commissioner noted that since the model is the cornerstone of the whole CARES effort it is very important that an effort be made to help the VISNs become familiar with it and learn how to use it.
- Except for priority level seven, the veteran population has a higher level of morbidity than private sector patients. For morbidity, the model adjusts Milliman data using a diagnosis-based risk assessment. A Commissioner commented that this situation has a large implication for the whole system.
- A Commissioner commented that the survey sent to veterans seems to be a key methodology for the model and asked whether there was some check against bias built into the survey, noting that individuals in lower economic levels and minorities were less likely to return a survey. Ms. Patterson replied that the key method used was analysis of the data for the over-65 population that VA purchased from CMS. CACI validated the survey results using actual workload data for the over-65 population then assumed that the same validity would apply to the under-65 population. The survey was a telephone survey taken by a market research firm.
- Asked about "supply constraints," Ms. Patterson said that supply constraints do slip into the model, but only at national level. No adjustments are made locally.
- Asked how the 2003 end-of-year ELDA enrollment figures were projected, Ms. Patterson said they were projected by market by priority level.
- A Commissioner asked about the inclusion of data from State homes in the model. He noted that State veterans' homes are the largest provider of skilled nursing for veterans. They are totally outside of the VA's control and that VISN planning processes don't include them. However, the Congress considers them to be a part of the available supply of care, so the issue is how much they should count against mandatory requirements. Another Commissioner noted that this subject relates back to the discussion about whether the unit of measure should be "enrollees" or "patients." Ms. Patterson reiterated that the model is built around claims data, with

76 percent of the enrollees creating the claims. Again, unlike the private sector, veterans have a choice of where they get their health care, so reliance is an important factor in this discussion. Veterans do not get all of their health care from VA, as was just noted.

- A Commissioner asked whether such supply factors as DoD treatment facility closings are considered in the model. Ms. Patterson said they are not, but that VISN planners have to take these factors into account at local level. Mr. Berkowitz added that VISN planners have to take supply, which is not considered in the model, into account in what they do.

**Jay Halpern, Acting Director
National CARES Program Office
CARES Design**

Jay Halpern spoke with the Commission about the CARES program design, the assumptions that were used in the design process and how they were chosen.

Following up on the question-and-answer session with Kathi Patterson, Mr. Halpern explained that the lack of time prevented detailed service line projections (for oncology and urology, for example) from being included in the current cycle. Service line projections would have increased the size and complexity of the model that VISNs would have to deal with and probably wouldn't have changed the gaps substantially. Additionally, because the VA facilities planning system couldn't handle 50 separate service lines, similar services were combined. VA recognizes the need for service level modeling and will include it in the next version of the model.

The current CARES model focuses on space needs. Congress asked VA for a space plan, so CARES is a capital asset realignment project. The goal was to identify major changes in future capital needs in terms of both size and location. Space was the primary driver of the effort. In response to a question from the Commission, Mr. Halpern said that decision had been made by Dr. Mackay's Office (the Office of the Deputy Secretary). He also added that the staff never had much time to work with the model. Only 120 days were available. The time frame affected many decisions.

A Commissioner noted that different populations drive decisions about different services. The fundamental need is to match supply with demand at the service level. Mr. Halpern said that VA issues a "call" for projects every year, but until now it hasn't tried to systematically translate that into "facilities." What Congress asked for was a facilities plan.

Explaining the decisions that went into the modeling process, Mr. Halpern noted that when the VA health system was changed in 1996, the forecasts did not project a dramatic drop. In some areas, such as outpatient mental health, it wasn't clear how care should be delivered. Rather than project current utilization forward, VA decided to project

enrollment, then match baseline use to the private sector and adjust for the differences between the private sector and VA. He noted that everybody has supply constraints; the assumption is that VA has supply constraints that are more severe.

Observing that clinicians aren't necessarily going to change their practice patterns just because the CARES process produces data that shows how the needs are different, a Commissioner asked how VA will ensure that cultural changes get made. How will VA ensure that what's needed is what gets delivered in terms of specific services at the local level. VA also needs to make sure that service changes are related to plant and facilities capacity and that things like replacement age get considered. Mr. Halpern replied that changing patterns of practice is a challenge for local, VISN-level managers. VA uses a performance-based system that would translate the requirement into a performance measure. He said that VA has assessed the condition of all current space and knows how much is available and acceptable to meet projected demand.

A Commissioner observed that the services provided aren't necessarily the services that are needed and asked how VA makes sure that they match. Mr. Halpern cited the special disabilities planning done for CARES (for blind rehabilitation and spinal cord injury/disability) as an example of initiatives developed using service-level planning. The next step after CARES is strategic planning. Asked whether CARES had looked at prosthetics the same way, Mr. Halpern said it had not -- only for blind rehab and spinal cord injuries.

A Commissioner asked whether the CARES process was supposed to establish the services required for veterans across the country, and whether the goal was to develop the array of services veterans need. He asked Mr. Halpern to explain further the "next iterations" after CARES that he keeps mentioning. In reply, Mr. Halpern said that it would take a very detailed and expensive project to determine projected service-level needs. As far as the next iterations go, VA is redesigning its strategic planning process. Part of the redesign is integrating what CARES is doing into strategic planning. The goal is to make the strategic planning more robust. The redesigned process will pick up things that there was no time or data to deal with as part of the CARES process. These included nursing home care, traumatic brain injury and domiciliary care. The redesigned strategic planning process would also incorporate service-level planning.

Another Commissioner observed that being responsible for a hospital means being constantly aware of the patients' needs, regardless of what services the hospital has now. When the hospital becomes aware of that need, it should take steps to acquire whatever it needs to meet it. His concern is that field directors who use the CARES model might get something other than what they think they need. Mr. Halpern replied that should not happen. CARES will only provide space -- "boxes." What goes into that space in terms of programs and services will be an operational decision made at local level. VISNs didn't have to deal with the ELDA model until it was tied to something that affected them directly, namely their capital plans. This cycle is the first time the model has really gotten down into the organization.

A Commissioner observed that a private organization had been using two different tracks: planning and capital. To overcome shortcomings in this process, they forged a new model where the two tracks had to work together. She said what she is hearing is that VA may be headed for a similar situation where there are two tracks: traditional strategic planning and capital asset planning (CARES). Mr. Halpern replied that the model will provide the means for integrating the planning for both capital facilities and programs. The model has already been used for budget projections and is now being used for capital projections. It is necessary to link the two because capital budgets don't provide for operational staffing. Mr. Halpern was asked whether the processes are truly integrated or are they actually separate processes. He replied that until now, integrating the planning and budgeting processes has been a terrible problem. He said VA is getting better at it, but acknowledged that it isn't there yet.

Another Commissioner asked why the model projected demand for 50 separate service lines (as described earlier) if VA isn't going to use them. Mr. Halpern answered that the service line projections were used, but they were rolled up into broader categories for CARES purposes. There is a detailed crosswalk, developed by Jill Powers' office, that shows the roll-up. Mr. Berkowitz emphasized that CARES is a *space planning* model. He said the facilities people weren't able to handle 50 separate planning lines. Consequently, similar services were combined for space planning purposes. The Commissioner asked if the VISNs then have to translate these back into specifics for service line planning. Mr. Halpern answered in the affirmative, adding that headquarters tried to minimize what it sent out to the VISNs to avoid overload. However, they did send out the service-line projections to the VISNs. The Commissioner said it might have made more sense to let the VISNs deal with the raw data than with rolled-up data. Mr. Halpern agreed that they could have done that, but it would have introduced other issues. For example, service-level planning would have generated a matrix with over 1,000 cells -- 50 service lines times 22 VISNs. He noted that there was also resistance to using the year 2022 for planning instead of 2012. Using 2022 raised questions of confidence in the data. Using the roll-ups increased the confidence in the data. To have a planning initiative, the gap had to have a 25 percent difference plus threshold limits. This allowed planners to have confidence that the projections would hold up under policy changes, such as those presented by the President's budget decision.

A Commissioner said he is concerned that they will hear that the plan that meets CARES requirements doesn't meet the needs of veterans. Mr. Halpern said that VISN have been asked for "macro-level" results -- how they will handle the need for 20 extra beds, for example. He expects that what the Commission is likely to hear when it holds field hearings will focus on questions of "proximity." He also thinks that what will take the Commission's time is the proposed response -- closure, consolidation, etc. He thinks closure of facilities, while possible, isn't likely to be a major issue because there are alternative uses of the facilities.

A Commissioner said that the Commission should be looking at how to deliver the best possible care to veterans. Mr. Halpern replied that different organizations, including OMB, have their own expectations. That's where the reaction will come from. He also

expects that the Commission will need to get involved in questions of timing and strategy (building versus contracting for new space).

A Commissioner observed that the Medicare proposal (Priority eight medical care) is getting a lot of attention and that if it passes it will require a lot of planning. He asked what the impact of enactment would be on primary care, etc. Mr. Halpern said new priority eight enrollments haven't been built in to the model. In fact, the assumption is that there are no new enrollments allowed for priority eight. As things happen to change the assumptions, VA will have to re-run the model.

Asked about budget figures for CARES, Mr. Halpern said that the ELDA model was used for budgeting. The CARES program doesn't need a budget. All of the Planning Initiatives will have cost numbers associated with them and approved initiatives will have to be built into the budget process.

Addressing the "small facility" question (the "40-bed" issue), Mr. Halpern said that the process started off with just the demand-supply model. When "proximity" was added as a factor, it was recognized that small facilities were an issue. The question that had to be answered was "What is a small facility?" Originally, 50 beds was used as the cut-off point, but that the definition was reduced to 40 beds because of the long-term time frame involved in the projections. About 21 facilities are projected to have 40 beds or less (acute care) in 2012-2022. An important finding was that VA facilities often are located in the right places.

Mr. Halpern concluded by noting that it took a contractor a whole year to do one VISN. CARES was going out to VISNs who had no resources to devote to it. This was part of the decision to keep the effort at a high level. It was important to consider what the system could absorb.

Allen Berkowitz, Senior Actuary
Office of the Actuary
Determining CARES Market Areas

Dr. Berkowitz reviewed with the Commission the process used to define CARES market areas. He referenced TAB 5 in the Commission's binder along with a new set of materials he handed out.

He began by summarizing that the CARES Office is charged with working on capital asset realignment in the context of the existing VA strategic plan. In all, CARES looked at over 400 problems that produced 200 discrete planning initiatives -- access to care, facility conditions, collaborative opportunities, special population groups and so forth. His discussion will look at the planning issues that applied to VISNs 1 (New England), 3 (New Jersey/New York City) and 16 (Arkansas, Mississippi, Oklahoma and Louisiana).

The CARES Office got input from the VISNs on defining market areas. Since July, 2002, CARES has worked with three different data sets: (1) the ELDA 02 Model (which

only went out to 2010), (2) the Vet Pop model without 2000 Census data, and (3) the Vet Pop model with 2000 Census data. CARES has followed the pattern developed in the Pilot, adjusted for "lessons learned." The main adjustment made was that the pilot focused on small issues whereas the overall CARES program focuses on much larger ones.

The CARES target is the total veteran population. Projections show that the total veteran population will decline in every VISN, with the South and Southwest declining the least. VA projected the age and priority level of veterans for every county in the U.S., then aggregated counties into market areas. The basis for aggregation was that areas had to have sufficient geographic size and population to benefit from the coordination of health care services and to support a full health care delivery system.

The CARES Office gave VISN planners the option of defining sub-markets. VISN planners defined sub-markets in many different ways. The criteria for sub-markets were that they had to have at least 30,000 enrollees and be a large geographic area without an urban center.

The data sources used for market analysis included:

- Vet Pop projections: Vet Pop 2000 and Vet Pop 2001
- Enrollment projections -- ELDA 02 and the enrollment file
- Census 2000 -- civilian population by county (to determine urban or rural).

Materials were provided to the Commission showing the types of maps and spreadsheets provided to the VISNs for developing market areas. These included: market share by county -- tables of total veteran population and enrollment by county; maps showing urban, rural and highly-rural areas (only a limited number of areas could be designated as "highly rural" because of the different travel standard); and maps showing the access measurements (the application of the distance standard).

CARES "urban areas" are identical to Census Bureau "urbanized areas" (populations of 50,000 people and a density of 166 people per square mile). "Rural areas" are defined as those with less than 166 people per square mile. "Highly rural areas" are defined as those with a population density of less than 50 people per square mile. Mr. Berkowitz also observed that 500 counties in the U.S. have no VA enrollees.

Several types of maps were displayed. One map showed projected veteran population by county, indicating VA facilities, including hospitals, clinics, benefit offices and cemeteries, including shared markets (of which there are many). Other sets of maps showed the enrollee population by county, market share projections by county (based on the ratio of Vet Pop to enrollees) and projected veteran population by county showing road systems, especially Interstate highways (for determining access) along with distance indicators (60-mile and 30-mile radius from facilities). For CARES purposes, proximity is defined in terms of distance converted to driving time. A separate analysis was performed to determine access -- how many enrollees have access to what kinds of

primary care by county. Access is based on geography only, not other factors (such as "wait time").

Based on the maps and spreadsheets provided by headquarters, VISNs developed their proposed market areas. They also developed projected market shares for each area based on information about which users go to what facilities. VISN proposals, along with the rationale for them, were presented to VISN-level CARES Committees and stakeholders. After this process, final maps, spreadsheets, data and detailed rationales (especially the estimated percentage of enrollees meeting access guidelines) were submitted to the CARES Office and then to the Under Secretary for Health for approval.

In all, the CARES program defined 77 market areas with 30 sub-markets using updated enrollment and Vet Pop data. Mr. Berkowitz showed how the three VISNs he was discussing had broken their jurisdictions into market areas (4 market areas for VISN 1 - New England; 3 market areas for VISN 3 - New York City and New Jersey; and 4 market areas for VISN 16 - Mississippi, Oklahoma, Florida and Louisiana) and discussed the characteristics of those market areas. He also reviewed the data and charts the three Commission teams would use for their afternoon meetings and summarized some of the tools used in developing the charts (such as the access calculator, a tool to recalculate access time as a result of building, moving or removing a facility).

Q&A/Discussion

Commission questions developed the information that the contractor, Booz-Allen, used a different process for the pilot program in VISN 12. As a result, stakeholders didn't have much involvement in that VISN. For the main CARES process, stakeholders didn't question the methodology and only questioned the result in one Network (the Rocky Mountain area, where the VISN wanted Wyoming to be defined as a market area to establish a basis for proposing a primary care hospital where none exists now).

In response to a Commissioner question, Mr. Berkowitz said that VA has data on how many people cross market area lines to get service, but there are no restrictions. Another Commissioner said that there are various reasons why enrollees cross lines, including the need for specialized services and personal preference.

A Commissioner asked whether there are any maps that show the relative degree of integration or cooperation between VA units or with DoD organizations. Mr. Berkowitz replied that throughout the CARES process there had been dialogue with the Department of Defense about opportunities for cooperation, but no maps have been developed to show possible integration. Where collaborative opportunities exist, the Commission will be given information to show whether the VISNs exploited or rejected the opportunity and why. Additionally, the CARES Office produces a report every two weeks that reports on what the VISNs are doing.

In response to a Commission question about what the reaction has been to the need for change in markets where there is a projected decline, Mr. Berkowitz replied that there are no primary care retraction issues. Other Commissioners noted that the field hearings would be held before the President's budget for 2004 is approved and asked about the possible reaction to that. The answer was that the President's budget affects primarily long-term enrollment. From the viewpoint of planning initiatives, it won't make much difference whether or not the President's budget is approved, although the size of the solution may be different.

Concerning the issue of long-term care and where it fits in the CARES program, Mr. Halpern told the Commission that VA originally thought it would have nursing home projections for this cycle. In the end, they were unable to develop them, so there will be no domiciliary, nursing home or long-term psychiatric care planning initiatives in this cycle. VA will get outside help with the forecasting, then include them in the next cycle.

In answer to Commission questions about possible alternatives, such as State homes, Mr. Halpern said that the VA doesn't have any projections to work with. Without them, there is no basis for a planning initiative. Another Commissioner asked whether VA could make safety improvements, such as making a nursing home "seismic" safe. Mr. Halpern said VISNs could propose things like that, but that NCPO was not initiating an agenda for nursing homes.

**Jill Powers, Deputy Director
National CARES Planning Office
Planning Initiatives**

Ms. Powers began by explaining that the VISN Service Support Center (VSSC) helped the VISNs develop their plans and also provides staff support to the National CARES Planning Office. She said her presentation would be an expanded version of the briefing on Planning Initiatives (CARES step three) that she gave the Commission at its first meeting and referred the Commission to TAB 6B for the briefing materials she would be using.

Ms. Powers reviewed key definitions:

- CARES categories -- For the CARES program, types of health care were grouped into 17 categories (such as inpatient medicine, inpatient surgery and mental health and outpatient primary and specialty care. CARES planning initiatives were developed for only six of the 17 categories.
- Gaps -- The difference between what was being supplied in 2001 and the amount projected to be demanded in future years out to 2022.
- Planning initiatives (PIs) -- Basically, planning initiatives represent "big gaps" in service demands that need to be resolved. PIs were developed for gaps that met threshold criteria.

- Collaborative opportunities -- the opportunity for sharing, selling or joint ventures. Collaborative opportunities were not defined as "planning initiatives," they were just identified.
- Access -- It's not where the veterans go, it's how long it takes them to drive there -- whether VA has the services within 30 miles, 60 miles, 90 miles., etc. Each type of market has separate access criteria:

	<u>Urban</u>	<u>Rural</u>	<u>Highly Rural</u>
Primary.....	30 mi	30 mi	60 mi
Acute.....	60 mi	90 mi	120 mi
Tertiary.....	4 hrs	4 hrs	Within VISN

- Proximity -- Improving the cost-effectiveness and quality of health care. The criteria are: two or more acute hospitals within 60 miles of each other and two or more tertiary hospitals within 120 miles of each other. Acute hospitals were defined as those providing basic medicine, surgery and psychiatric services. Tertiary hospitals are those which provide specialty care such as cardiology (high cost/low volume). The VISNs developed the listings.

A Commissioner observed that for many years the issue has been facility duplication stemming from medical school affiliation. Ms. Powers said that "access" and "proximity" are linked.

- Small facilities -- to ensure appropriate quality of care in a cost-effective manner, the small facilities criterion was defined as the existence of an acute hospital projected to have fewer than 40 acute medicine, surgery and psychiatry beds in FY 2012 and FY 2022. If a facility was projected to have less than 40 beds, it was looked at the see if it meets quality standards.

A Commissioner asked whether this definition meant for "all services." Ms. Powers replied it was for "medicine, surgery and psychiatry combined."

The key issue was "workload capacity." CARES looked at gaps with a 25 percent difference or an absolute volume of 20 beds difference (plus or minus) for inpatient services in 2012 or 2022. In answer to a question, Ms. Powers said that some facilities had gaps in one year but not the other. CARES wanted both years looked at.

- Vacant space -- The criterion used for selecting PIs to reduce "vacant space" was a reduction by 10 percent in FY 2004 and 30 percent in FY 2005. These goals were also incorporated into the performance plans of VISN Directors according to Mr. Halpern.

In regard to vacant space, a Commissioner expressed the view that vacant space being converted to other uses (such as shelters for the homeless) shouldn't be counted. Ms. Powers agreed, stating that only permanently vacant space was considered for this category. She also said that the system has provided a way for some programs to convert

space and use it. In response to a Commission question, she said that overall, nine percent of VA space is vacant now (that is, not being occupied for any purpose).

The different types of collaborative opportunities that were looked at in connection with CARES included co-locating Veterans Benefit Administration (VBA) offices and considering the National Cemetery Administration's need for land and office space and other "enhanced use" opportunities. Additionally, DoD identified sharing opportunities and possible joint ventures.

A team of five people identified and prioritized the gaps, then prioritized planning initiatives based on the size of the gap. Gap sizes were standardized to ensure their uniform application throughout. The team also spent time "walking through" each VISN, looking at all key aspects of each VISN -- geography, number of facilities, enrollee trends, affiliates, research budgets and collaborative opportunities.

There was also a senior leadership review process involving representatives from headquarters and the VISN Directors. After this review, top management of VA and key stakeholders were briefed on the planning initiatives.

Planning initiatives were developed around identified gaps -- the difference between projected demand and what is being delivered now. Gaps were analyzed for access (the percentage of enrollees in a market within travel guidelines as well as the absolute number of enrollees), for proximity (the number of miles between facilities) and for small facilities (number of beds). Wherever access criteria did not meet the standard, a planning initiative was identified.

Ms. Powell then reviewed the actual data and selection process used for one sample VISN -- VISN seven (Alabama, Georgia and South Carolina) -- to demonstrate how markets, gaps and planning initiatives were identified. The applicable material was referenced as TAB 6D in the Commission binders. Ms. Powers first summarized the key characteristics of the VISN as shown in the maps and charts provided to the Commission:

- The VISN has three markets. The markets follow Congressional District lines, not state lines.
- All three markets met the Planning Initiative standard for "primary care" access; two markets met the standard for "acute care" access.
- Based on the "proximity" standard, no PIs were identified in VISN seven for acute care, but some were selected for tertiary care.
- The VISN has one facility that meet the standard for a small facility PI (an acute care facility in Dublin, Georgia).

In developing planning initiatives, the team applied other considerations. These included: (1) VISN capacity (tried to limit to three PIs per market). (2) Strength of trend (a "strong trend" was one that met the 25 percent absolute volume gaps in 2012 and 2022; a "moderate" trend met the criteria in one year but not both). (3) Source of gap (population-based gaps -- where the veteran lives-- are different from treating facility gaps -- where the veteran goes for treatment.) Workload was allocated to treating

facilities, but the program looked at why people might cross market lines (such as overloaded facilities and living on the border).

Ms. Powers also presented and discussed detailed data, maps and charts that were developed by CARES for each of the individual markets in the Network, showing how the gaps were identified and converted into formal Planning Initiatives. The tabular material showed the size of the gaps projected for 2012 and 2022 by type in each CARES category.

The Commission asked questions about the specific market information provided in the spreadsheets and graphs, where it had come from and what the meaning of it was. Additional discussion developed additional information about the data and the model. All demand projections for 2012 and 2022 are based on actual 2001 experience. The NCPO had a study conducted that detailed what level of services had been provided in 2001. In some cases (such as outpatient care) there would be a very large difference in the gap projected if supply numbers were used instead of demand. Ms. Powers said that a person running a hospital really wants to know how many times somebody walks through the door for a procedure (a "stop").

In answer to a question about mental health projections, Ms. Powers said that if mental health demand in a VISN was projected to go down, the NCPO flat-lined it at county level for 2012 and 2022. She emphasized that NCPO did not flat line all counties -- only those with negative projections for 2012 and 2022. This was a national decision. Mr. Berkowitz said that how the mental health area was dealt with in CARES had been a hotly debated subject. Some studies suggest that older people stop seeking mental health treatment. One Commissioner noted that there is a tremendous variation in whether mental health outpatient services are provided by the CBOCs.

Ms. Powers emphasized that CARES Planning Initiatives were identified jointly by the NCPO team and the VISNs, but that the VISNs have also identified other issues and initiatives that aren't part of CARES. These include issues such as expiring leases and the condition of existing space. The CARES Team added up all of the vacant space and produced grids; all excess space will be looked at.

Mr. Halpern observed that there is some vagueness in how CARES is dealing with nursing home care and vacant space. The Under Secretary for Health is concerned that the program not use VA vacant space for nursing homes. A Commissioner noted that the private sector is switching from nursing home care to "assisted living." Mr. Halpern said VA is looking at that option. Dr. Roswell wants VA to be a "cutting edge" health care system and asked the VISNs to give special consideration to "tele-health" and "tele-medicine" projects.

Team Meetings

Chairman Alvarez announced that the Commission would organize into three teams of five Commissioners each to conduct field hearings:

TEAM 1:

- Commissioners: Binard, Colley, Ferguson, Pell and Wyrick.
- Staff: Wiley, Adams.
- VISNs: 10, 11, 15, 16, 17, 18, 21.

TEAM 2:

- Commissioners: Battaglia, Kendall, Ray, Vogel, Webb.
- Staff: Fry, Amundsen, Collier
- VISNs: 1,4,5,6,9,22,23.

TEAM 3:

- Commissioners: Alvarez, Boland, McCormick, Vandenburg, Zamberlan.
- Staff: Bednarz, Renaker, Judy.
- VISNs: 2,3,7,8,19,20.

Each team held an initial meeting to review the demand data, gap analysis and Planning Initiative proposal selection process for a sample VISN. Each Team went through the process that Ms. Powers just described, but for a different sample VISN. In each case, an NCPO staff member presented the basic data about the VISN to set the stage, after which detailed data and information was presented to and reviewed by the Commission Team and staff. The purpose of the session was to give the Commission "hands on" experience in working with the data that was used to identify gaps and develop planning initiatives. The Commission will have access to this data on-line for all VISNs and markets as it proceeds with its review and recommendations, so it is important that they become familiar with it.

The data presented and discussed for the sample VISNs included: geographic information, parent/subordinate facility relationships and locations, funding and staffing for facilities, VISN-wide enrollee trends, enrollment projections by market, market share by market, other VA lands and facilities (cemeteries, for example) in the VISN, and tables depicting access situations for each market area. The Commission Teams then reviewed the CARES criteria (access, proximity, small facilities) to determine gaps and discussed which had been made into Planning Initiatives and why.

Discussion of Commissioner's Concerns

The Commission reconvened as a whole to discuss progress and concerns. In response to the Chairman's request for comments on the process so far, various Commissioners offered the following:

- Concern was expressed that the Commission doesn't have a handle on the total demand. The inability to get at unmet demand is bothersome.

- Differences in the definitions used for outpatient mental health services are a concern. The gap identified for planning is determined using figures for current mental health services being delivered. The problem is that current services include rehab services that aren't included in the demand projection model. This results in artificially widening or narrowing the gap. The gap should be determined using "apples-to-apples" comparisons.

Later in the meeting, it was stated that the model incorrectly included 1,209,000 visits that went into the mental health workload calculations -- more than 13 percent of the total workload. This is a national average; discrepancies could be more serious by VISN and market. Mr. Berkowitz asked that the described discrepancy be provided to NCPO. NCPO will research the issue and get back to the Commission at the next meeting.

- Another Commissioner expressed concern that demand from Vet Centers is not included in the model. There is a lot of Congressional interest in the Centers, which were originally focused on Vietnam veterans. Veterans who are not enrolled can use the Vet Centers -- they are not limited to health care. Vet Center users are not automatically enrolled in the VA health care system.
- One Commissioner expressed a desire to be briefed on the most challenging issues for the VISNs the Commission will visit. Mr. Larson replied that he and the staff plan to brief the Commission on key issues and regional matters in the June meeting. The staff was requested to include information on consolidations already done by the VISNs and stakeholder reactions.
- Several Commissioners expressed concern about the shortage of time available for Commission review, especially if the Commission decides it should intervene. There was a brief discussion of the possibility of asking for a time extension. The Chairman indicated they weren't likely to get one. One Commissioner said it isn't clear what authority the Commission has to ask for consideration of alternatives, or even to ask the VISNs to explain their recommendations. Mr. Larson explained that any queries the Commission has will have to go back to Dr. Roswell for processing. The Commission can approve, reject or modify what's included in the plan, but exactly what that involves is not clear. The Chairman observed that the process used will have to evolve as situations develop.
- Concern was expressed about VA's military backup mission. One Commissioner asked for a briefing on VA-DoD contingency planning.
- The Commission complimented the staff on the work they have done to prepare briefing materials.

Thursday, March 13, 2003

**Dr. Barbara Chang,
Consultant for Clinical and Academic Affairs
CARES Program Office
Special Disability Compilations and Programs**

Dr. Chang began by observing that the program directors think of their programs as addressing special populations, whereas the CARES perspective is to look at the services being provided. It is important to capture the whole array of services required by the population.

The CARES model was designed for micro-level planning. Private sector benchmarks are lacking for special disability populations, so the CACI model didn't work for special populations. Special disability treatment is part of the VA mission. Consequently, her team had to figure out a special approach to programs with Congressionally mandated requirements: blind rehabilitation, seriously and chronically mentally ill, homeless, spinal cord injury and disorder and traumatic brain injury. In each of these cases, the Directors wanted more services. She referred the Commission to TAB 9 in the binders -- the history of CARES decision-making and who was involved in the process.

The CARES Program Office is still studying models that would link special populations to projected utilization. For the seriously and chronically mentally ill (SCMI) population, CARES is trying to come up with a model that would indicate what the appropriate utilization is and link back to special populations. The lack of private sector benchmarks for domiciliary beds is the big issue. The big problem with the data (which is described in a briefing paper under TAB O) was what was happening with domiciliary beds, for which there are no private sector benchmarks. CARES used national figures with the result that units having few beds went down while markets having many beds went up. Approximately 80 percent of VA domiciliary bed patients are in the SCMI population. The SCMI Group and the Office of the Medical Inspector is reviewing the situation. In the meantime, CARES holds the number of domiciliary beds constant at the 2001 level until it figures out what and where it wants the programs to be.

For inpatient psychiatry, the original projections showed wild swings, stemming from the fact that only two of five components had private sector benchmarks. CARES flagged this as a non-benchmarked program and held it constant pending further study.

VA has four traumatic brain injury (TBI) centers. Their workload is included in the general CARES database, but it isn't separated out. A research project has been set up to develop data on access to services and geographic distribution. This work is in progress and will be available next year.

In the end, the CARES program used alternative models for two special population groups: blind rehabilitation and spinal cord injury and disorder. Dr. Chang discussed with the Commission how the Planning Initiatives for these were developed.

The prevalence models for blind rehab were well along, so CARES was able to use those as a basis. The models were tied to projections of where veterans live and appropriate utilization rates were applied. Dr. Chang noted that there was a wide fluctuation. In answer to a Commission question about whether the blindness had to be service-related to qualify for treatment, Dr. Chang said it does not. The incidence of macular deterioration is age-related, so it is easy to project demand using in-house data. The blind

rehab model is considered quite robust. For this population, VA was able to use all inpatient data, where the data is the best available.

Blind Rehabilitation

For blind rehab, CARES recommended two new centers (in VISNs 16 -- Louisiana, Mississippi and Oklahoma -- and 22 -- Southern California) on a base of 10 units in eight networks now. There is also a free-standing two-week outpatient program in Pennsylvania called VISOR -- Visual Impairment Services Outpatient Rehabilitation. The blind rehab recommendations are based on projected demand for bed days of care converted to beds. CARES is also recommending attention to a spectrum of care that includes outpatient rehabilitation.

For spinal cord injury and disorder, CARES planning initiatives, based on a similar methodology, included four new units. They are to be located in VISN 2 -- Upstate New York, VISN 16 -- as above, VISN 19 -- Colorado and Wyoming, and VISN 23 -- Nebraska, the Dakotas and Minnesota. In response to a question, Dr. Chang indicated that the recommendations for new facilities are being made by the CARES multidisciplinary team. They also were sent to the VISN Directors for further development and both the blind rehab and spinal cord initiatives were presented to the Under Secretary and the Secretary before being approved.

Data for spinal cord injuries was obtained from Paralyzed Veterans of America. A key difference between blind rehab and SCI is that SCI is limited to priority levels one through four. People with spinal cord injuries are "catastrophically disabled" (priority level four) whether or not the injury is service connected. Overall, VA is currently serving less than the Congressionally mandated level of 803 beds.

A Commissioner observed that a lot of spinal cord injury patients go outside VA for services and asked if they are included in the model. Dr. Chang said they are only included if they have been to the VA, too.

Q&A/Discussion

A Commissioner said there have been complaints that the waiting time to get into the Centers is too long, that their size is too limited or that they are too far away. He asked if CARES is addressing these capacity issues. He understands that there are 2,000 vets waiting for blind rehab services. Dr. Chang said that a lot of Centers are not operating at full capacity because of budget and staff limitations, but the beds are there. The throughput for blind rehab patients is about 2,000 patients a year with 1,800-2,300 patients on the waiting list.

Asked if there was a standard regarding how soon after diagnosis a patient should be provided with treatment, Dr. Chang said that utilization patterns vary all over the country depending on access. Inpatient programs just can't meet all the needs. VA is emphasizing expansion of outpatient programs, although different types of patients use

outpatient services. The utilization rate is only 80 percent due to staff deflation. Dr. Chang identified this situation as something VA needs to work on. When asked if this situation had influenced the projections, Dr. Chang said only marginally.

A Commissioner observed that CARES went to great pains in its models to establish acceptable distances from facilities. He expressed the view that for severely disabled populations such as these, the first criterion ought to be "acceptable wait list time." If patients aren't treated in a reasonable amount of time, the system has already lost an opportunity. He thinks the agency might be getting lost in the minutia for its other services while missing out on the idea of setting an acceptable limit for an important population.

A Commissioner observed that the presentation implied that the VA inpatient population for blind rehabilitation is in the hospital for some other reason. When Dr. Chang agreed with that observation, the Commissioner suggested that maybe the VISOR program (outpatient rehab) should include bed patients.

Another Commissioner expressed the view that the real cost of the program is the staff. The question is whether the program has the will to devote limited recurring resources to rehabilitation. Dr. Chang agreed that the programs are very staff intensive and require the specialists to provide a wide range of services. The programs are telling the CARES Office that they need more outpatient services.

The need for co-location of services was also discussed. There are places where blind rehab isn't co-located with other services and the problem isn't necessarily space availability. It's important to the patient not to have to travel too far. But it was also agreed that patients tend to go back to where they were originally treated. Patients can go where they want. VA is now using a "hub and spoke" approach to provide services.

Dr. Berkowitz further discussed the special population initiatives in greater detail. Initially, CARES looked at prevalence of special disabilities in the general population, then applied that rate to veterans. However, the SCI population is limited to priorities one through four; blind rehab involved all enrollee types. The CACI/Milliman data, which was based on VA national rates, were judged to be incorrect for this population. For SCI, VA had enrollment data, feedback from stakeholders and a rich external data set from the National Center for Health Statistics involving a sample of over 100,000 patients. In the end, CARES applied the civilian prevalence model to the veterans population, then adjusted for enrollment. For blind rehab, legally blind veterans were identified in each VISN.

Discussion of President's Budget Policy

Dr. Berkowitz stated there were 25 million veterans in 2000 and that VA would reach 40 percent market share in 2022 if enrollment continues. In response to that statement, the Commission discussed the validity of using as a baseline the President's budget that hasn't yet been enacted. The Commission understands that the program was instructed to use

the President's budget levels as a baseline, but voiced concern that it causes confusion to keep redoing the models for scenarios that probably will not happen. The view was also expressed that a significant number of priority-level seven veterans are primary care users and will pay the \$250 enrollment fee. Further, trends in private sector health care plans are likely to encourage eligible veterans to enroll in the VA system. On co-pay, the result will depend on what happens with Medicare prescriptions.

In response to a Commission question about the net difference between the two sets of assumptions, Dr. Berkowitz replied that there is a gross difference of about 1.5 million enrollees in 2022. For the biggest users of the system -- priorities one through six -- no change would result from the policy proposals. Only two percent of priority-level seven veterans are users of the system, and most sevens are now eights.

Another Commissioner pointed out that most veterans already have to pay for health benefits, and noted that some will not find \$250 to be a deterrent. Furthermore, hourly wage people are going to be asked to start making payments for their health care benefits. As that happens, it will cause more people to enroll in VA, skewing the numbers upward. Other Commissioners pointed out that without the \$250 enrollment fee, the numbers would skew upward even more and that one major difference between the VA program and outside insurance is that outside insurance provides coverage for the whole family. Most VA-eligible enrollees will probably use both.

Dr. Berkowitz said that VA will have to run the model after all of the decisions are made and look at the facility needs then. There is a built-in time lag anyway.

Mr. Halpern informed the Commission that the Senior Research Group had this same debate. The only choice was to stop CARES, which was unacceptable and, since the changes were minimal (less than 2.5 percent), unnecessary.

The fact that special disabilities have been flat-lined hasn't been an issue with stakeholders so far.

Continuation of Special Population Presentation

Dr. Berkowitz displayed a map showing the geographic distribution of the legally-blind enrollee population. The map shows that VISN 16 (the Louisiana, Mississippi & Oklahoma area) has the highest prevalence and no blind rehab facility. Congress mandates that VA maintain 238 beds for blind rehab without specifying where they should be. Where the VA beds are now, demand rises to 390 in 2012 and 363 in 2022. However, there will also be demand in VISNs where VA has no blind rehab now. A Commissioner pointed out that the geographic size of a VISN affects the number of legally-blind enrollees it will have.

Dr. Berkowitz next presented a chart showing utilization by VISN in terms of beds (bed days of care converted to beds). NCPO calculated the number of bed days per 1000 enrollees. The results showed that the average utilization rate is 2,839 for VISNs that

have blind rehab centers, whereas the utilization rate for VISNs without centers is 50 percent of that. The reason is that enrollees have to go outside their VISN to get access to care. Gaps were projected by applying the utilization rates to the number of enrollees.

A Commissioner observed that the numbers are artifacts of how the VISNs were created. They favor networks that are geographically large. Dr. Berkowitz agreed that the geography varies from VISN to VISN. Nationally, however, the numbers show that there is growth and the need for more beds. The question is where to put them. The CARES approach wasn't one of "just build it," it was "think about treatment needs." In answer to another Commissioner's question, Dr. Berkowitz said that VISOR programs are administered at VISN level, but they are unevenly distributed.

Spinal Cord Injury and Disorder

For the spinal cord injury and disorder program, NCPO used the same approach. The main source of data for spinal cord injury and disorder was the Paralyzed Veterans of America. An important difference from the blind rehab program is that spinal cord injuries are focused on priority groups one through four. The data is based on users coming from the SCI register. These four priority groups represents a very high percentage of the total veterans population -- about 52 percent -- and this would be true under any budget scenario.

Dr. Berkowitz next presented data showing the projected number of enrollees with spinal cord injuries and disorders. A Commissioner asked if veterans with spinal cord injuries are automatically in priority four. He said he is concerned we might be underestimating the number in priorities five, six and seven. Dr. Berkowitz answered that veterans with spinal cord injuries are "catastrophically disabled" -- priority category four -- whether or not the cause is service-connected. In response to a Commission question, Dr. Berkowitz said that the Congressional mandates are based on 1996 levels.

Two different utilization rates were developed to show the effect of adding centers where VA doesn't yet have them: projections based on SCI "enrollees" and projections based on SCI "users." The "users" approach, which estimates the actual number of users for 2001, was chosen. This approach shows growth of 1.5 percent per year and overall use approaches the mandated levels in 2022.

Dr. Chang referred the Commission to TAB K, exhibit 2B. This exhibit shows data that could be used to justify putting an SCI in every Network.

Asked about how many SCI patients received care in non-SCI centers, Dr. Chang said that the figures included anybody who has sought care from the VA since 1988. In response to a Commission question, she also said that there is no waiting list problem with spinal cord injury care.

Referring the Commission to TAB I -- the long-term care model -- Dr. Chang pointed out that the exhibit shows total beds broken down into three components: mandated beds, designated beds and priority beds. All are included in the Planning Initiative for SCI -- the long-term SCI projections are all inclusive -- which reduces the size of the gap.

A Commissioner asked what the reaction from stakeholders had been to the special disabilities that had been straight-lined, especially from VSOs. Dr. Chang said there had been almost no reaction, that straight-lining hasn't been an issue. Where there had been feedback, it has come from the National level of the VSOs, not from their local organizations. The Commissioner expressed concern regarding what kind of recommendations the Commission would be able to make in the absence of feedback.

Mr. Halpern observed that it shouldn't be a problem for the Commission since there are no Planning Initiatives for Special Disabilities. In those cases, what happens next is that VA headquarters will integrate CARES into the strategic planning process for next fall. At that point, they plan to add in the things that had to be left out for this round of CARES.

Mr. Halpern told the Commission that the blind rehab and SCI programs just barely managed to get included in this round of CARES. The other programs were not included because there wasn't enough good data. The programs are in the process of developing that data now. He also observed that the stakeholders will be weighing in on these matters -- the VISNs have to report what the stakeholders have to say about each Planning Initiative.

In response to a Commission question whether there had been any attempt to co-locate traumatic brain injury (TBI) and spinal cord injury and disorder, Dr. Chang reported that the Paralyzed Veterans of America have been very opposed to such action.

**Jay Halpern, Acting Director
National CARES Program Office
Long-Term Care (LTC) Model**

The principal issue in long-term care is need, which has been more difficult than other areas to estimate and forecast. Market share is a difficult policy issue, as is the mix between State-operated facilities and in-house VA or contracted facilities. A key VA strategy has been to meet the mandated bed caps using State facilities; the Millenium Bill would prohibit this approach. Discharging Priority 1-As is also an issue.

For long-term care, NCPO looked at use rates by age, gender, and enrollee type. It also determined the ADL (active daily living) limitations status of veterans by taking an internal survey and applying the results to the overall enrollee population.

In answer to Commission questions, Mr. Halpern said that ADL is an important determinant of an individual's ability to live in the general population. The data were

derived from an internal survey. One Commissioner noted that priority 1-As are a very different and unusual population. VA has good data on this population; it knows why they are 70 percent disabled. Mr. Halpern said that priority I-As are broken out in the model, but not modeled separately. Another Commissioner said that he had been asked to participate in a VA survey recently that had a lot of ADL questions and that it seemed pretty comprehensive to him. Mr. Halpern identified it as the "hospital feedback survey" and said it was a good source of data.

Mr. Halpern continued his description of the long-term care model by explaining the formula used to determine "need." The model calculates by multiplying use rate times population times market share. The formula was applied at the facility level by year and priority group. The data on use rates was for males by age and disability level. Population data was based on projected enrollment. The output of the model, an average daily census, was converted to beds and projected by year by priority group to market and VISN and nation-wide. The data came from surveys taken in 1996, 1998 and 1999. This approach enables VA to determine what percentage of the total market VA will be able to meet.

The need for nursing home care is based on the average daily census that comes out of the model. An "IADL" factor -- Instrumental Activities of Daily Living -- is used to determine a patient's ability to move from a hospital environment to other care arrangements, such as home health care. Overall, 70 percent of nursing home bed patients are discharged to home.

Discussion

In response to Commission questions about the data used in the long-term model, Mr. Halpern said he didn't know whether female patients were included, that the data in the Commission's tables shows the rate of use of nursing homes for various ADL levels, and that State homes were probably not included. A Commissioner observed that the need projections would not be very useful without State home data. Mr. Halpern agreed, indicating that obtaining State home data was an area in need of improvement.

A Commissioner commented that the Millenium Bill assigns priority for care to group 1-A only. He believes it would make more sense to model this mandated care group first, then model the optional groups. He noted that past practice in VA goes contrary to that mandate. Mr. Halpern replied that he doesn't understand why VA's market share is dropping in long-term care. The cost of VA care is zero because it's an entitlement. There is no reason for it to go down. The Commissioner observed that VA nursing homes are maxed out; it's hard to get eligible people into them. The service and need have to match. Another Commissioner noted that State home beds are growing significantly and that this should be factored into VA's planning.

Mr. Halpern summarized the effect of the President's budget policy decisions on long-term care. For Priority group 1- A, care is mandatory; for all other groups it is non-

mandatory. Also, the full range of VA programs is available for priority 1-A: post-acute rehabilitation, GEM, RESPITE, long-term care and spinal cord injury/disease. For priority groups 1-B through 8 the Presidential policy decision is: no long-term care; limited post-acute rehabilitation; limited GEM; limited RESPITE; full Spinal Cord Injury. System-wide, 40 percent of patients are receiving post-acute care and 40 percent are receiving long-term LTC. He will provide more detailed figures on the numbers associated with each category to the Commission.

The Chairman observed that long-term care won't be on the Commission's agenda since there are no Planning Initiatives for it and asked about the overall model used for long-term care. Mr. Halpern replied that, overall, the target set was 16 percent of market share. NCPO proposed removing the 16 percent overall because the priority 1-As are using all of that market share. It also proposed separate, independent targets for mandatory and non-mandatory. Proposals to set mandatory caps at 65 percent of market share and to hold mandatory care categories level were rejected. NCPO also proposed an adjustment for a healthier aging population and demographic shifts, but the VISNs objected to those proposals. The final result was that within VA people couldn't agree on how to change the projections for what factors and what to set for market share targets. So long-term care was flat-lined for this go around. The status of nursing homes in the VISN market plans is unclear. Some proposals may be submitted by the VISNs, but they are not being pushed by NCPO.

In answer to a Commissioner's question, Mr. Halpern said that "beds" are equal to 90 percent of "bed days of care." That conversion is standard for all of VA.

Another Commissioner said it is bothersome not to have an integrated model yet because the State home piece of the market is so large. A large number of the beds that VA calls "domiciliary care" the States consider to be "assisted living" beds. The problem is that the populations for the two types are different. There is no breakdown of priority categories. Mr. Halpern said that comparable data can be obtained by looking at internal VA ADL scores, then re-computing. The Commissioner replied that operational decisions are currently being made "on the ground" as to which veterans belong in VA facilities and which in State facilities. Mr. Halpern agreed, observing that VA planning focuses on that fact. The Millenium Bill is an issue in this regard. There is a real need to sort out the split between VA and the States. VA has taken a position that the issue needs to be resolved by June to get the results into the next planning cycle.

A Commissioner asked whether older data on trends is available. Mr. Halpern agreed to check on availability.

Market Plans

Mr. Halpern referred the Commission to binder TAB 10 for the "market plan" materials. He reviewed the process of weighing and ranking the potential projects to be included in the VISN market plans. NCPO began with the criteria that had been developed for use in

the Pilot Phase of CARES in VISN 12. NCPO considered applying the same process used for the Pilot Phase to rank potential projects and service delivery options for VA as a whole. However, the process produced results that were clustered closely together. Using this process for 20 VISNs with hundreds of projects would have made decision-making extremely difficult. To avoid this outcome, NCPO developed a new model with two types of criteria: (1) threshold criteria, such as safety and quality, that would produce a "pass or fail" result, and (2) impact criteria, which could be used to assess the impact of potential projects on such factors as the local community, employees, the teaching program, research, etc. He said potential projects could have a negative impact and still be considered, but the VISNs had to develop a strategy for overcoming the negative impact. VISN were instructed to apply these criteria to two alternatives for each gap.

As a result of applying the criteria, the Planning Initiatives are mostly expansions of primary care facilities. There are very few inpatient reductions included in the list of planning initiatives, so there aren't many negative impacts. Where they do exist, the process will identify and deal with them.

Originally, the CARES Office asked the VISNs to develop exact plans for what would happen in 2012. That guidance was since changed to ask the VISNs to develop a general strategy.

Mr. Halpern noted that the operational costs of the capital realignment initiatives haven't yet been estimated. VA has invested in a life-cycle costing model to identify the most cost-effective alternatives. The VISNs are entering data into the cost models and the results will be included in the market plans.

With regard to capacity of the system as a whole, VA hasn't been able to get any detailed guidance on capacity concerns to use for estimating. VA isn't proposing to change its capacity yet. The "surge" issue -- capacity to absorb casualties associated with national emergencies -- is a staffing issue for VA (i.e., staff availability is more critical than bed availability). Every VISN has been asked to look at how many beds it could make available in different time periods -- 24, 48 and 72 hours. Mr. Jenkins added that VA was currently looking at how many empty beds are in the system, how many beds could be contracted out and how many empty beds could be created by shifting patients.

Discussion

The initial discussion of impact criteria centered around the effect on medical school affiliates of changes in the VA system. It was noted that some medical schools have reacted negatively to the distances involved in traveling to the CBOCs from the medical schools. Since there is no authorization to pay travel expenses, this could be a big issue. However, most medical schools have reallocated their pools and are also moving to emphasize primary and outpatient care. The schools will not be deterred by distances if VA provides them with the opportunity to work in specialized fields. VA has plenty of opportunities and the number of residents is not increasing. It was also noted that the

cost of medical school resident slots is increasing and that this is becoming a major problem for some schools.

One Commissioner said that he, as a Commissioner, expects to hear from the VA unions about the negative impact of the proposed changes. The unions may feel that the changes have a negative effect even if facilities aren't being closed. This is because shifting staff from their home base into the community affects the union members -- there could be fewer support jobs, relocations might be involved, etc.

In response to Commission questions about the cost models used, Mr. Halpern said that the market plans will include the results of the cost analysis for all alternatives (not just the proposed solution), that operational costs will also be included in the proposal and that proposal will make clear whether the costs are capital costs, lease costs or operating costs.

Handbook for Market Plan Development

Mr. Halpern walked the Commission through the template that NCPO developed for use by the VISNs in putting together market plans. The template outlines headquarters' expectations and requires enough information to have the basis for further conversations about the VISNs' choices. He stressed that the goal of the analysis was not to bring things to closure, but to get back good analysis of the situation and the options for resolving it. Mr. Halpern chose the *small facility* and *proximity* initiatives to illustrate the template.

For *small facility* initiatives (40 beds or less in 2022), the template focuses on quality, not just costs. It requires that VISNs specify and consider alternatives. It also requires them to assess the environment and look at the capital investments needed to maintain the environment. Alternatives are to be examined for efficiency (staff proficiency), for specialty care and for recruitment and retention (how to increase them). NCPO tried to build in quality indicators. Mr. Halpern said they didn't have a lot of indicators for inpatient care, but there are more for outpatient care. Among other things, VISNs were specifically asked to look at nurse staffing turnover and the availability of workers in health care fields important to the VA mission.

VISNs were also asked to look at opportunities to increase their workload through actions such as future collaboration with small rural hospitals. NCPO wants the facilities to think through all of their options to see if they are able to take their services to another level. The template further asks VISNs to look at the effect on referral patterns, potential travel times, the impact on other facilities and the cost of referral centers where consolidation is considered as an option.

The idea is to cause the facilities to think through all of the avenues available to them, including closing acute beds and moving patients to State facilities. Mr. Halpern said it is hard to imagine that VA wouldn't grow as a result of improvements in primary and secondary care.

Regarding *proximity* initiatives, Mr. Halpern said he expects that there might be some consolidation of services in high-cost places like New York. Some closures are also possible. In general, there are three options available for resolving proximity issues: (1) maintain the status quo, if justified; (2) retain only one facility where there are two now; and (3) retain both facilities, but consolidate services. The VISNs were also asked to look at administrative services consolidation.

Similar analytical processes were used for all CARES criteria, not just small facility and proximity gaps. For increases in workload capacity, for example, VISN were asked to consider three alternatives: (1) how to manage the increase in-house; (2) managing by contracting out the workload; and (3) establishing a new site of care.

Mr. Halpern said that the Commission will be receiving and reviewing proposals at this level of detail and analysis (by facility, by criterion for each alternative). He also noted that NCPO will already have reviewed it first.

When NCPO receives the market plans (April 1), it will have to turn them around in six weeks. Consequently, if NCPO decides to take on an issue, that initiative will be less likely to reach the Commission for review. The Under Secretary has the option of not including a particular Planning Initiative in the draft National CARES Plan.

Discussion

During discussion of the market plan template, a commissioner identified as an issue the question of how "cost" is defined in the analyses for purposes of determining whether to choose the in-house or contracting out option. He said the question is what to include in the "cost" -- specifically whether facilities are required to factor depreciation into their analysis. Mr. Halpern offered to provide that information to the Commission, agreeing that it is an important issue.

The Commission identified small facility analysis as the key to success for CARES and expressed some frustration at how little time has been provided to do the work. Mr. Halpern agreed that the small facilities would require a lot of hard analytical work. NCPO will give the Commission the best possible product to work with, although the time available is very compressed.

A Commissioner observed that the VISN 12 pilot program identified boundary issues that there was no way to accommodate and asked whether the CARES process allowed for boundary resolution. Mr. Halpern answered that CARES would provide for resolving any boundary issues between facilities.

The Executive Director asked whether a decision had been made about whether to forward CARES Program Office comments on the market plans to the Commission. Mr. Halpern said that NCPO hadn't thought about that, but he believes that the comments could be sent along with the plans and that they would be helpful to have. The problem would come with proposals that needed more discussion and analysis. He said that any proposal that was so flawed that it had to be sent back to the VISN to be re-worked would probably not re-surface until the next planning cycle, although stakeholders might disagree with that outcome. The Commission agreed that it wants to know about any reservations that the Under Secretary has with a proposal, even if it is included in the draft Plan. One Commissioner pointed out that the Commission is likely to hear about any proposals sent back anyway, so it would be useful to know the Under Secretary's views. Mr. Halpern agreed that NCPO would give the Commission not only the plans but also an understanding of the decisions that the Under Secretary makes. He also observed that the charter for the CARES Commission includes reviewing the process used and suggested that the Commission might want to include comments on it in the report.

Mr. Halpern noted that the VISNs have a built-in incentive to do a good job. One penalty for not doing quality work is that the proposal would not be included in the capital plan that's going to Congress. There might be other penalties as well, but the incentive is to do a good job.

In discussing the role of stakeholders, Mr. Halpern noted that the GAO had cautioned against stakeholder participation. Despite that advice, the VA determined that VSOs and other stakeholders would be in the best position to review and comment on the Planning Initiatives.